NORTH CAROLINA PROVIDER ENDORSEMENT APPLICATION

Organizations that desire to render services to North Carolina eligible Medicaid Recipients must be endorsed by the Area Authority/County Program in order to complete the Division of Medical Assistance enrollment process.

Complete this application and submit with required attachments in compliance with the Policy and Procedures for endorsement under Section I entitled Framework for Establishing Provider Qualifications.

Application Date_____

SECTION I: CORPORATE INFORMATION

1. Legal Name of Organization (as used for tax reporting purposes):

_____

Federal Tax ID # _____

Organization Address: (Street)

_____

City: _____ State: _____ Zip Code: _____

County: _____ Office Hours: _____

Number of years doing business under this name: _____

Website Address: _____

Has this Organization ever been in business under a different name? Yes ☐ No ☐

If yes, what name? _____

Primary Contact: _____

Primary Contact's Title: _____

Primary Contact's E-mail Address: _____

Telephone: Office: _____ Fax: _____

Mobile: _____ Pager: _____

Executive Director: _____

Clinical/Medical Director: _____

2. **Has any owner, director, officer, administrator or staff ever been convicted or charged with a crime other than a minor traffic offense, in any state or country?**

Yes ☐ No ☐
(If yes, please attach an explanation and any supporting documentation.)

3. Organization Legal Entity Type:

□ C-Corporation	□ General Partnership	□ Cooperative
□ S-Corporation	□ Sole Proprietorship	□ Not for Profit
□ Limited Liability Corporation	□ Limited Liability Partnership	□ Government

Note: If your Business/Organization has a filing status as listed above, you must submit a copy of the "Articles" filed with the NC Secretary of State in their entirety.

4. Is this Organization accredited?: (If yes, attach verification of accreditation.)

JCAHO:	Yes ☐	No ☐	Years accredited? _____	Expiration Date: _____
CARF:	Yes ☐	No ☐	Years accredited? _____	Expiration Date: _____
COA:	Yes ☐	No ☐	Years accredited? _____	Expiration Date: _____
CQL:	Yes ☐	No ☐	Years accredited? _____	Expiration Date: _____
OTHER:	Yes ☐	No ☐	_____	

5. Has the Organization ever been sanctioned, placed on probation or lost accreditation or certification status? Yes ☐ No ☐
If yes, attach an explanation of the circumstances and how it was resolved.

6. LIABILITY INSURANCE:

	Yes	No
1) Have you ever had a claim against you? (If yes, please list the name and amounts of the insurance and disposition.)	☐	☐
2) Are there any current, unsettled claims? (If yes, please attach explanation.)	☐	☐
3) Are you aware of any circumstances that may result in a claim or suit? (If yes, please attach explanation.)	☐	☐
4) Have you ever had a policy cancelled? (If yes, please attach explanation.)	☐	☐

7. Has there ever been any action or investigation against you or any owner or qualified professional in your Organization relating to (If yes, please attach explanation.):

	Yes	No
1) license?	☐	☐
2) certification?	☐	☐
3) registration?	☐	☐

Yes No

4) privileges?	☐	☐
5) billing Organizations?	☐	☐

8. Have any adverse actions been filed against you by

(If yes, please attach explanation.)	Yes	No
1) Medicaid?	☐	☐
2) Medicare?	☐	☐
3) Other Insurance?	☐	☐

9. Has anyone in your company who has an ownership, managerial or clinical role ever been sanctioned by any professional organization or government Organization for violation of ethics, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?

	Yes	**No**
(If yes, attach explanation.)	☐	☐

10. Are you aware of any circumstances that may result in such an action?
(If yes, attach explanation.)

Yes	**No**
☐	☐

11. Have you ever had a contract cancelled by another Area Authority/County Program in North Carolina or similar entity in another state?

	Yes	**No**
(If yes, attach explanation.)	☐	☐

12. Please list all relevant contracts your Organization currently has and/or has had for the past three (3) years. (Skip to the next question if you have no contracts.)
Please include for each:

A) Contracting Organization/Area Program LME
- Contact name
- Phone number
- E-mail address

B) What services are/were provided?
C) Beginning and ending dates.
D) Dollar amount of contract.

If your Organization has not had any contracts for services within the past three (3) years, describe the experience and resources key personnel have had in providing requested services for adult and/or child/adolescent consumers.

SECTION II. FACILITY/SITE SPECIFIC INFORMATION – A facility/site is a physical location where supervisor and or management of services occur. If your Organization operates more than one facility/site, copy and complete this section for each facility/site.

Facility/Site Name:

_____

Facility/Site Address:

_____

City: _____ State: _____ Zip: _____

County: _____ Facility/Site Hours: _____

Telephone: _____ Fax: _____

Information about the Facility/Site Director/Supervisor:

Facility/Site Director's Name:_____

Facility/Site Director's Education: _____

Facility/Site Director's Credentials:_____

1. **Is this facility/site licensed by?** (If yes, attach a copy of the license.)

   DFS: Yes ☐ No ☐ license #: _____ State: _____

   DSS: Yes ☐ No ☐ license #: _____ State: _____

   Other: Yes ☐ No ☐ Type: _____
   license #: _____ State: _____

2. **If you are applying to provide a service which does not require licensure, please submit a completed Self Study of Core Rules. Completed Self Study is attached.** Yes ☐ No ☐

3. **Is this facility/site staffed and equipped to serve:**

Physically Handicapped?	Yes ☐ No ☐	Deaf & Hearing Impaired?	Yes ☐ No ☐
Blind/Visually Impaired?	Yes ☐ No ☐	Behaviorally Disruptive?	Yes ☐ No ☐
Sexually Aggressive?	Yes ☐ No ☐		
Foreign Languages?	Yes ☐ No ☐ (Specify)_____		

4. **Coverage:** Indicate what arrangements you make to cover consumer emergency situations during nights, weekends, and holidays (skip if you are requesting endorsement for Diagnostic Assessment only):

_____

_____

_____

_____

5. Physician Coverage: Indicate what arrangement you have made or are planning to make to cover your Organization for consumers who need psychiatric evaluation or psychiatric medication.

List psychiatrist/physician who will see your consumers:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

6. Do you have a manmade, natural disaster, or act of God crisis/disaster plan?

☐ Yes ☐ No (If yes, please attach.)

7. Have you had a corporate endorsement for the provision of MH/SA/DD services in North Carolina? ☐ Yes ☐ No

If yes, by which Area Authority/County Program: _____

Please check the service(s) for which you are applying for endorsement and those for which you are already endorsed.

Please note that accreditation is required for all services listed below with an *.

SERVICE	APPLYING FOR ENDORSEMENT	WHICH AREA AUTHORITY/COUNTY PROGRAM ARE YOU ALREADY ENDORSED BY
*Ambulatory Detoxification		
*Assertive Community Treatment Team – ACTT		
Child and Adolescent Day Treatment (MH/SA)		
*Community Support – Adults (MH/SA)		
*Community Support – Children/Adolescents (MH/SA)		
*Community Support Team – CST (MH/SA)		
*Developmental Therapy Services		
*Diagnostic Assessment (MH/DD/SA)		
*Inpatient Hospital Psychiatric Treatment (MH)		
*Inpatient Hospital Substance Abuse Treatment		
*Intensive In-Home Services		
*Medically Supervised or ADATC Detoxification/Crisis Stabilization		
*Mobile Crisis Management (MH/DD/SA)		
*Multisystemic Therapy – MST		
*Non-Hospital Medical Detoxification		
*Psychiatric Residential Treatment Facility – PRTF		
*Psychosocial Rehabilitation – PSR		
*Social Setting Detoxification		
*Substance Abuse Comprehensive Outpatient Treatment Program		
*Substance Abuse Halfway House		
*Substance Abuse Intensive Outpatient Program		
*Substance Abuse Medically Monitored Community Residential Treatment		
*Substance Abuse Non-Medical Community Residential Treatment		
*Targeted Case Management for Individuals with Developmental Disabilities		
Facility Based Crisis Program		
Opioid Treatment		
Day Treatment – Child		
Personal Care		
CAP Services		

SECTION III. INFORMATION TO BE SUBMITTED

Information included in items (1 through 6) is required at a 100% level in order for the application to be considered for further evaluation and approval.

1. Submit an annualized budget and the most recent certified audit or most recent board approved financial statement, if applicable. (only required for corporate endorsement)
2. Submit written documentation of source of authority through charter, constitution and/or by-laws or articles of incorporation. (only required for corporate endorsement)
3. Submit an Organization chart. This chart will include any major programs, program heads/supervisors as well as staffing patterns for each service applying for. The chart will also show the Organization's standing committees and their reporting structure as well as any ancillary positions.
4. If an out-of-state Organization, submit a certificate of authority that shows eligibility to do business in NC (obtained from the Secretary of State's office). (only required for corporate endorsement)
5. If Organization is privately owned, submit listing of duties of Owner/CEO. Provide documentation of qualifications via resume/curriculum vitae. (only required for corporate endorsement.)
6. Submit list of board of directors (names, titles and contact). Provide documentation that includes required qualifications of board members, method to determine a quorum, and officers' length of term. (Sole Proprietors are excluded from this item requirement.) (only required for corporate endorsement)
7. Submit a conflict of interest procedure (required for private, non-profit Organizations). (only required for corporate endorsement)
8. Submit a copy of the Certificate of Insurance or letter of intent from the Organization's proposed insurance carrier that meets the minimum amounts required for the location in which you are applying for endorsement.
9. Submit proof of automobile insurance for company vehicles, and employee (include contracted employees) vehicles that are used to transport consumers.
10. Submit written references that contain the reference person's name, telephone, and e-mail information. References must include:
    - one from an individual familiar with fiscal operations of the facility. If the Organization is a new business the reference must pertain to the fiscal stability of the board/CEO/Owner to support the company financially.
    - one from an individual familiar with the clinical operations of the Organization. If the Organization is a new business the reference must be obtained from someone familiar with the clinical director's qualifications and abilities.
    - two from individuals currently receiving services and/or family members. If the Organization is a new business the references must be obtained from individuals involved in the field of disabilities either professionally or through life experience.